MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

03380

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Fort Geo. G. Meade Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Grace A. Orth

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 4, 1870

8. AGE: Years	Months	Days	If less than one day
75	8	1	hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Retired clerk
11. Industry or business: U.S. Treasury Dept.
FATHER 12. Name: Joseph A. Orth
13. Birthplace: Washington D.C.
MOTHER 14. Maiden name: Henrietta Sodia
15. Birthplace: Washington, D.C.
16. Informant: Mr. & Mrs. Hugh Marcellus
Address: Gambrills, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 8, 1946 (month) (day) (year)
Cemetery or crematory: Congressional
Location: Washington D.C.
18. Funeral director: J. M. Lee & Sons.
Address: Washington, D.C.
19. 4-5-46 (Date rec'd by registrar) E.J. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 5 1946, at about 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jany. 2 1940 to Apr. 3 1946
and that I last saw h[illegible] alive on April 3 1946

Immediate cause of death: Acute dilatation of heart — DURATION: minutes
Due to: Arterial hypertension — 6 years
~~Due to~~: Arterio-Sclerosis — 6 years
Cholecystitis — 2 years
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffey M.D.
Address: Annapolis, Md. M. D. or other
Date signed: 4/5/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

03381 23
Reg. Dist. No.

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: C. C. Co
City or town: BROOKLYN.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 DAYS
Hospital, Institution, or street address where death occurred: 5725 ~~Route~~ RITCHIE HIGHWAY
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County: —
City or town: BALTIMORE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 320 GWYNN AVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME WAYNE LOUIS BOYER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JULY 18 - 1945

8. AGE: Years | Months: 8 | Days: 22 | If less than one day: ..... hrs. ..... min.

9. Birthplace: BALTO MD
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: EDWIN. BOYER.
13. Birthplace: BALTO MD

MOTHER
14. Maiden name: RUTH. STORM
15. Birthplace: BALTO MD

16. Informant: EDWIN BOYER
Address: 320 GWYNN AVE

17. BURIAL (Burial, cremation, or removal? Which?) Date thereof: 4-12-46 (month) (day) (year)
Cemetery or crematory: London Park
Location: Balto Md

18. Funeral director: Mrs Chas a G. Rohde
Address: 3327 Edmondson Ave

19. 4-11 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1946, at 600 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1945 to April 10 1946 and that I last saw him alive on April 8 1946

Immediate cause of death	DURATION
Bronchio Pneumonia	2 days
Due to: Tracheo-Laryngeo Bronchitis (Acute)	3 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE Eliot W. Johnson M.D. M. D. or other
Address 3432 Fredericks Date signed 4/10/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

03382

Reg. Dist. No. 28—

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years, 3 months
Hospital, Institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 28 years, 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill (If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown (If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: BRATTEN - BELITHA

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widower

6.(b) Name of husband or wife: ———
6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): 1863

8. AGE: Years: 83 Months: unknown Days: If less than one day: ——— hrs. ——— min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Lawyer (?)
11. Industry or business: ———

FATHER
12. Name: Amos Bratten
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Truitt
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-13-46 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville
18. Funeral director: Supt Hospital
Address: Crownsville Md

19. 4-13-46 19.... E J Joyce Local Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1 19 46, at 3:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 19 18, to April 1 19 46
and that I last saw him alive on April 1 19 46

Immediate cause of death: General Arteriosclerosis — DURATION: Known to us since 1/1/18
Due to: ———
Due to: ———
Other conditions: Involutional Psychosis — Known to us since 1/1/18
(Include pregnancy within 3 months of death)

Major findings of operations: ———
Date of op.: ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of: ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ———
Means of injury: ——— Injured at work? ———

23. SIGNATURE: Albert V. Bratten M. D. or other
Address: Crownsville, Maryland Date signed: 4/1/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

03383

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County a a

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County a a

City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 41 Madison St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ellen Anne Brewer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 18 - 1864

8. AGE: Years	Months	Days	If less than one day
81	11	5	...hrs. ...min.

9. Birthplace Annapolis Md
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Jackson Brewer
13. Birthplace annapolis md

MOTHER
14. Maiden name Annie McGehee
15. Birthplace Annapolis Md

16. Informant Annie Brewer
Address 41 Madison St Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 26/46 (month) (day) (year)

Cemetery or crematory St Annes

Location Annapolis Md

18. Funeral director B. L. Hopkins

Address Annapolis Md

19. April 26 19 46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 19 46, at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 38, to April 24 19 46 and that I last saw h... alive on April 24 19 46

Immediate cause of death	DURATION
Hypostatic Pneumonia & Myocardial Degeneration	10 days
Due to	
Due to	
Other conditions Arteriosclerosis	Years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Brewer M. D. or other

Address Annapolis Md Date signed 4-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03384 P

Reg. Dist. No. 25

1. PLACE OF DEATH:
County Anne Arundel
City or town Brooklyn Hgts. (Balto. 25)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 9 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Anne Arundel
City or town Brooklyn Hgts. (Balto. 25)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 212 Doris Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Burke

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Thomas H. Burke
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 11, 1865

8. AGE:

Years	Months	Days	If less than one day
80	9	3	____ hrs. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business

FATHER
12. Name John Schley
13. Birthplace Germany

MOTHER
14. Maiden name Annie (nee?)
15. Birthplace Germany

16. Informant Mrs. Lillian Burke (Daughter-in-law)
Address 212 Doris Ave., Brooklyn Hgts. 9.9.6., Balto. 25, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 17, 1946 (month) (day) (year)
Cemetery or crematory Mt. Carmel
Location Baltimore Md.

18. Funeral director A. W. Edward Evans
Address 1400 S. Charles St. Balto. 30, Md.

19. 4/16 1946 A. W. Hedrick DM Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1946 at 1:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 1946 to April 14 1946 and that I last saw h[er] alive on April 13 1946

Immediate cause of death	DURATION
a. Acute Bronchitis	
Due to b. Hypostatic pneumonia	
Due to c.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____
Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE P. M. Kinslow M.D. M. D. or other
Address 302 Talapsa Date signed 4/15/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

03385

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Best Gate - P.O. Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 58 years
Hospital, Institution, or street address where death occurred:
died suddenly on old rail road track at Best Gate Md.
How long in hospital or Institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: P.O. Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Best Gate
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: William Carroll

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Married

6.(b) Name of husband or wife: Amelia Carroll
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): 1888

8. AGE: Years	Months	Days	If less than one day
58			hrs. min.

9. Birthplace: Best Gate A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: general utility man

11. Industry or business: None

FATHER
12. Name: Samuel Carroll
13. Birthplace: Anne Arundel Co. Md.

MOTHER
14. Maiden name: Jennie Boston
15. Birthplace: Anne Arundel Co. Md.

16. Informant: Mrs Maggie Foote
Address: 4 Colonial Ave. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/24/46 (month) (day) (year)
Cemetery or crematory: Fowlers Chapel Cemetery
Location: Best Gate Md.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. April 24 1946 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20, 1946 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____
and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Gustave A. Faubert M.D. or other
Address: Glen Burnie Md. Date signed: 4/20/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

03386

Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town Bay Ridge Road Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, Institution, or street address where death occurred:
Bay Ridge Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County a a

City or town Rural Eastport
(If outside city or town limits, write RURAL and give nearest town)

Street No. Bay Ridge Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Florence Lee Chapman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Leland L. Chapman

6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) June 17 - 1890

8. AGE:

Years	Months	Days	If less than one day
75	10	7	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Home wife

11. Industry or business

FATHER 12. Name Robert Wood

13. Birthplace Maryland

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Leland L. Chapman

Address Bay Ridge Road Eastport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27/46 (month) (day) (year)

Cemetery or crematory Cedar Cliff

Location Annapolis Md

18. Funeral director B. I. Hopkins

Address Annapolis Md

19. April 27 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1946, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to April 24 1946 and that I last saw h. alive on April 24 1946

Immediate cause of death	DURATION
Coronary Thrombosis.	
Due to Arteriosclerotic C.V. disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address Eastport Md Date signed 4/26/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03387

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 20 minutes

Hospital, institution, or street address where death occurred:

Annapolis Emergency Hospital

How long in hospital or institution? a few minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: R.F.D. Box 541 Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. Defense Highway

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Alexander A. Colonell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lola Colonell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 15th 1881

8. AGE:

Years	Months	Days	If less than one day
65	1	24	hrs. min.

9. Birthplace: Novgorod Russia (Town, county, and state)

10. Usual occupation: Draftsman

11. Industry or business: U. S. Naval Academy Annapolis

MOTHER FATHER

12. Name: Unknown

13. Birthplace

MOTHER

14. Maiden name: Unknown

15. Birthplace

16. Informant: Louis J. Allen

Address: 3419 R. St. N.W. Washington DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15th 1946 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Prince Geo. Co. Md

18. Funeral director: John M. Taylor-Son

Address: Annapolis Md.

19. April 15 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 12 1946, at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post Mortem Examination 19.. ~~and that I last saw him alive~~ on Apr. 12 1946

	DURATION
Immediate cause of death: Coronary Thrombosis	sudden
Due to: Coronary Sclerosis	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D Deputy Medical Examiner

M. D. or other

Address: Annapolis Md Date signed 4/15/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (D)

CERTIFICATE OF DEATH

03388

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 80 Jennifer Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Jane Cox.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Charles W. Cox
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 18th 1889

8. AGE:	Years	Months	Days	If less than one day
	56	5	24	hrs. min.

9. Birthplace: Ellison W.Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: J.J. Bragg
13. Birthplace: Raleigh Co.

MOTHER
14. Maiden name: Rhoda E. Cox
15. Birthplace: Ellison W.Va.

16. Informant: Mrs L.E. Donaldson
Address: 623 E. Capitol st. DC

17. Removal — Date thereof: April 13-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory:
Location: Hinton West Va
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.

19. April 13 1946
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12-46 at 7.25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15-45 to April 12-46 and that I last saw h[illegible] alive on April 10-46

Immediate cause of death	DURATION
Acute Cardiac Failure	
Due to: Primary carcinoma of breast. Duration: One year. Op. & R.	
Due to:	
Other conditions: Metastatic Carcinoma	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Date signed: April 12-46

9

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

03389

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town P. O. Pasadena - Long Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County A. A.
City or town P. O. Pasadena.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Long Point.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Harry Crowley.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed.

6.(b) Name of ~~husband~~ or wife Mrs. Lilly Wright

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.) 10/19/67

8. AGE: Years	Months	Days	If less than one day
78	6	1	....hrs. ....min.

9. Birthplace Stockport - New York State
(Town, county, and state)

10. Usual occupation Upholsterer

11. Industry or business

FATHER
12. Name Frederick Crowley
13. Birthplace Washington D.C. U. S. A.

MOTHER
14. Maiden name Anna Small
15. Birthplace York, Pa. U. S. A.

16. Informant Mrs. L. Popp - (daughter)
Address Long Point - P. O. Pasadena, Md.

17. Burial Date thereof April 23 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Loudon Park
Location Baltimore
18. Funeral director Frederick H. Cole
Address 1200 W Lombard St

19. 4-27-46 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1946, at 8:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 — to — 19
and that I last saw h— alive on — 19

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? —
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Gustave H. Pankenbank. Assistant Medical Examiner ~~M.D.~~ or other
Address Glen Burnie, Md. Date signed 4/20/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03390

Reg. Dist. No. 22

1. PLACE OF DEATH:

County A. A. Co.

City or town Elvaston (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A. Co.

City or town Hanover (If outside city or town limits, write RURAL and give nearest town) Rural

Street No. Drury - Hanover Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Carol Sylvester Bailey.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	col.	

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 29 - 1946

6.(c) If dead, give age years

8. AGE: Years X | Months X | Days 2 | If less than one day hrs. min.

9. Birthplace Elvaston Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name James Hebron
13. Birthplace Elvaston Md.

MOTHER
14. Maiden name Jeanette Bailey
15. Birthplace Elvaston Md.

16. Informant Edna L. Bailey

Address Elvaston Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 30/46 (month) (day) (year)

Cemetery or crematory St. Mary's.

Location Near Elvaston

18. Funeral director The H. C. White Co.

Address Laurel Md.

19. April 30 19 46 Clara Hasbrook
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 19 46 at 5 20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 19 46 to April 29 19 46 and that I last saw h. alive on April 28 19 46

Immediate cause of death Hysteria

Due to Breech- presentation

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Shipley, M.D.
M. D. or other

Address Savage, Md. Date signed 4/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (946)

03391

CERTIFICATE OF DEATH

Reg. Diat. No. ——

1. PLACE OF DEATH:
County: Anne Arundel Co
City or town: Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A. A.
City or town: Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main Ave & Hill Top Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Russell R. Dana

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Hattie S. Dana
6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): June 16, 1867

8. AGE: Years: 78 | Months: 10 | Days: 7 | If less than one day: ... hrs. ... min.

9. Birthplace: New York City (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business: Dry Goods

FATHER
12. Name: Samuel Jr. Dana
13. Birthplace: N. H.

MOTHER
14. Maiden name: Helena Raymond
15. Birthplace: ?

16. Informant: Hattie S. Dana
Address: Main Ave & Hill Top Road.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Apr 26-1946 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: 3801 Frederick Road.
18. Funeral director: Jos. Jos. John H. Gentzel & Son
Address: 801 W. Fayette St.
19. 4/25 - 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23, 1946, at 7:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 1, 1946, to April 23, 1946
and that I last saw him alive on April 23, 1946
Immediate cause of death: Angina Pectoris — DURATION: 2 mos
Due to: General Debility
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: ... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ... Injured at work?

23. SIGNATURE: Thos. H. Phillips, M. D. or other
Address: 1939 Edmondson Date signed: 4-23-46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

03392

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Annapolis Co

City or town: Eden Park Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Joseph Philander Delphey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Wh.	Widowed

6.(b) Name of husband or wife: Mary Elizabeth Delphey

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Apr 8 - 1856

8. AGE: Years	Months	Days	If less than one day
90		4	hrs. min.

9. Birthplace: Carroll Co. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Joseph Philander Delphey

FATHER — 13. Birthplace: Pa.

MOTHER — 14. Maiden name: Deliliah Lewis

MOTHER — 15. Birthplace: unknown

16. Informant: Lulu Benchoff

Address: 218 N. Taylor Ave Kenmore Apts

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 15 46 (month) (day) (year)

Cemetery or crematory: Rawlins Cemetery

Location: Norman Md

18. Funeral director: Raymond F. Wright

Address:

18. April 13 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13 1946 at 7 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to April 13 1946 and that I last saw him alive on April 12 1946

	DURATION
Immediate cause of death: Myocarditis + Myocardial Insufficiency	unknown
Due to: Arteriosclerosis	unknown
Due to:	
Other conditions: Benign Prostatic Hypertrophy	unknown

(Including pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: George C. Bail M. D. or other

Address: Annapolis Md Date signed: 4-13-46

Dr Basil
Franklin Hospital
Dr Frenk

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

03393

CERTIFICATE OF DEATH

Reg. Dist. No. 191-23

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Ferndale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 4 6 mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Ferndale (If outside city or town limits, write RURAL and give nearest town)

Street No.: Broadview Ave (If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Alice May Dennis

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George Wm. Dennis

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 30, 1865

8. AGE:

Years	Months	Days	If less than one day
81	-	23	..... hrs. ..... min.

9. Birthplace: Unity, Montgomery Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John W. Dwyer
13. Birthplace: Montgomery Co. Md.

MOTHER
14. Maiden name: Adlinda Bowman
15. Birthplace: Maryland.

16. Informant: Miss Minnie Dennis

Address: Ferndale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 26, 1946 (month) (day) (year)

Cemetery or crematory: Grace Church Cem.

Location: Elkridge, Md.

18. Funeral director: Easton Sons

Address: 608 Frederick Ave Catonsville Md

19. April 25, 1946 (Date rec'd by registrar) John B. Langhorn, Jr. B.E.E. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23, 1946, at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21 1946 to April 23 1946 and that I last saw he alive on 4/23/46 - 19.....

Immediate cause of death	DURATION
(a) arteriosclerosis	?
Due to (b) senility	?
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op.:

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury — Injured at work?

23. SIGNATURE: Gustave H. Parker Jr. M.D. (M. D. or other)

Address: Isley Buenie Md Date signed: 4/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

03394

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one hour ten minutes
Hospital, institution, or street address where death occurred:
Annapolis Emergency Hospital
How long in hospital or institution? one hour ten minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Parole
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Maryland St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah Dorsey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	married

6.(b) Name of husband or wife: Charles Dorsey
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Jan. 20 1898

8. AGE: Years	Months	Days	If less than one day
48	2	20	....hrs. ....min.

9. Birthplace: Davidsonville A.A.Co. Md.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: George E. Hillary
13. Birthplace: A.A. Co. Md.

MOTHER
14. Maiden name: Hattie Hawkins
15. Birthplace: A. A. Co. Md

16. Informant: Author B. Dorsey
Address: Parole, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 13, 1946 (month) (day) (year)
Cemetery or crematory: Davidsonville Cem.
Location: Davidsonville, Md.
18. Funeral director: J.B. Johnson
Address: Annapolis, Md.
19. April 11 1946 (Date rec'd by registrar) W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 10, 1946 at 2-50 P.M.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~
Post mortem Examination 19..
and that I last saw ~~her~~ alive on Apr. 10, 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	Sudden
Due to: Arterial Hypertension	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Coffey M.D. Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed:

03395 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Marley Park, Glen Burnie P.O. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Marley Park, Glen Burnie P.O. (If outside city or town limits, write RURAL and give nearest town)
Street No.: Queen Anne Road (If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: George W. Eslein
3.(b) Social Security Number: —

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: —
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): August 31, 1873
8. AGE: Years 72 Months 7 Days 23 If less than one day ... hrs. ... min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business: —
FATHER 12. Name: George W. Eslein
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Dorchester Co., Md.
15. Birthplace: Jane Bell
16. Informant: Mrs. Florence V. Wheeler (Sister)
Address: Queen Anne Rd., Marley Pk., Glen Burnie P.O., Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof: April 26, 1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cem.
Location: A. A. Co., Md.
18. Funeral director: G. Howard Evans
Address: 1400 S. Charles St., Balto. 30, Md.
19. 4/25 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23, 1946, at 2:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12-46 to April 23-1946 and that I last saw him alive on April 22-1946
Immediate cause of death: Acute Cardiac Failure — DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?
23. SIGNATURE: [signature] M.D. or other
Address: Odenton, Md. Date signed: April 23-46

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. A. T. Allen C3396

FILM No. I 0 4 MAY 22 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: A. A.
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 52 Pleasant st
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: A. A.
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
Street No. 52 Pleasant, st. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas Evans

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M Male	Colored	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Feb. 22 1888

8. AGE: Years	Months	Days	If less than one day
58 5-7	2	5	hrs. min.

9. Birthplace: Annapolis, (town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Louis Evans
13. Birthplace: A. A. Co.
MOTHER 14. Maiden name: Sophia Johnson
15. Birthplace: A. A. Co.
16. Informant: Frank Evans
Address: 52 Pleasant st.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 30/46 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis
18. Funeral director: J. B. Johnson
Address: Annapolis
19. April 29 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 27 1946, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4-21- 1946, to 4-27 1946 and that I last saw h[illegible] alive on 4-21- 1946

Immediate cause of death: Tuberculosis — DURATION

Due to:

Due to:

Other conditions: debility

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. T. Allen, M.D. M. D. or other
Address: 17 Carroll St. Date signed: 4-29-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

03397 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (185)

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH

County: Anne Arundel

City or town: Curtis Bay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? probably 7 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: New York County:

City or town: Lynbrook Lynbrook

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Charles Maxwell Galloway

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

B.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 13, 1919

8. AGE: Years	Months	Days	If less than one day
26	11	24	hrs. min.

9. Birthplace: Brooklyn, New York (Town, county, and state)

10. Usual occupation: S C 3 class

11. Industry or business: U.S. Coast Guard

FATHER 12. Name: ?

FATHER 13. Birthplace

MOTHER 14. Maiden name:

MOTHER 15. Birthplace

16. Informant: U.S. Coast Guard

Address: Curtis Bay Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 9-1946 (month) (day) (year)

Cemetery or crematory: Rockville Centre

Location: Long Island New York

18. Funeral director: Roff & B.M. Walters

Address: Pratt & Streeter Sts

19. 5/9 1946 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: about Apr. 29 1946 at unknown M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~

Postmortem Examination ~~as~~

~~and last saw deceased on~~ May 7 1946

Immediate cause of death	DURATION
Drowning	
Due to: Accident	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: Apr. 29 1946

Where did injury occur? Curtis Bay (City or town) A.A. (County) Md (State)

Injured at home, farm, industry, public place (where?): Curtis Bay

Means of injury: Drowning Injured at work? no

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner (M. D. or other)

Address: Annapolis, Md Date signed: 5/7/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

03398 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Davidsonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
Rutland Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If a newborn infant, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Davidsonville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rutland Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Maggie Mae Gary.

3.(b) Social Security Number: none

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: Geo. N. Gary
6.(c) If alive, give age: ... years
7. Birth date of deceased (mo., day, yr.): July 22, 1873
8. AGE: Years: 72 Months: 8 Days: 17 If less than one day: ... hrs. ... min.
9. Birthplace: near Savage, Howard Co., Maryland (Town, county, and state)
10. Usual occupation: retired housewife
11. Industry or business: Home
FATHER 12. Name: Alexander Bakers
FATHER 13. Birthplace: near Savage, Howard Co., Maryland
MOTHER 14. Maiden name: Mary Elizabeth Hailey
MOTHER 15. Birthplace: near Savage, Howard Co., Maryland
16. Informant: Mrs. Perry Watson
Address: Davidsonville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/11/46 (month) (day) (year)
Cemetery or crematory: Camp Meade
Location: Camp Meade, A. A. Co., Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.
19. 4/11 1946 (Date rec'd by registrar) A. W. Hedrick D.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 9 1946, at 8:35 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1944 to Apr. 9 1946 and that I last saw her alive on Apr. 9, 1946

	DURATION
Immediate cause of death: Cerebral Apoplexy	9 days
Due to: Cerebral Sclerosis.	4 years
Due to: Arterial hypertension	8 years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Cleffy, M. D. M. D. or other
Address: Annapolis, Md. Date signed: 4/19/46

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

47.37
96.39

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

03399

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Revell - P.O. arnold, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: R. D. Arnold
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Revell
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Frederick Theodore Gillmann
3. (b) Social Security Number: 215-14-9503.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife: Jennie Mae (Gillman) Shaffer
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): 5/20/1889

8. AGE: Years: 56 | Months: 11 | Days: 25 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Brooklyn, N. Y.
(Town, county, and state)

10. Usual occupation: Plumber.

11. Industry or business:

FATHER
12. Name: Frederick Gillmann
13. Birthplace: Germany

MOTHER
14. Maiden name: ? Emma Erdman
15. Birthplace: ? Unknown

16. Informant: Mrs. F. T. Gillman (wife)
Address: Revell - P.O. arnold, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29, 1946 (month) (day) (year)
Cemetery or crematory: Asbury M.E. Church Cemetery
Location: Arnold A.A. Co. - Md.

18. Funeral director: John M. Payer & Son
Address: Annapolis, Md.

19. April 29 1946 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1946, at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Gustave H. Faubert Md.
(Attending medical examiner) M. D. or other
Address: Glen Burnie Md. Date signed: 4/25/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

03460

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Gambrills R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Gambrills R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Burns Cross Roads
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George S. Gilpin

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Lucy Jane Gilpin
Nee-Doyle
6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) October 29, 1850

8. AGE:

Years	Months	Days	If less than one day
95	5	22	....hrs. ....min.

9. Birthplace Culpepper Va (Town, county, and state)
10. Usual occupation Boiler Maker (Retired)
11. Industry or business C+O.R.R. Co W. Va.

FATHER
12. Name John Gilpin
13. Birthplace Unknown

MOTHER
14. Maiden name Frances Walters
15. Birthplace Unknown

16. Informant Mrs. Brook Akers
Address Gambrills, Md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 24 1946 (month) (day) (year)
Cemetery or crematory Glen Haven
Location Glen Burnie, Md
18. Funeral director Thomas W. Quigley
Address Glen Burnie, Md

19. April 23 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1946 at 6:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1st 1946 to April 21 1946
and that I last saw him alive on 4/20/46 1946

Immediate cause of death	DURATION
Gradual Heart failure	1 3/4 mo.
Due to Arteriosclerosis	?
Due to senility.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Isadore H. Paules M.D. M. D. or other
Address Glen Burnie Date signed 4/22/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89-2)

03401

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: Anne Arundel Co

City or town: Foreman's Corner (Solly)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Foreman's Corner

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lucrisia Gontrain

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Robert M.

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): 12/23/1867

8. AGE:

Years	Months	Days	If less than one day
78	4	3	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: David Johnson

13. Birthplace: Md.

MOTHER

14. Maiden name: Virginia Rodgers

15. Birthplace: Md

16. Informant: Mr. David Ford

Address: Foreman's Corner A.A.Co, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/28/46 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Annapolis Blvd.

18. Funeral director: John F. Henry Inc

Address: 14 E. Eight St.

19. 4/29/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1946, at 5:03 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21 1946, to April 26 1946 and that I last saw her alive on April 24 1946.

	DURATION
Immediate cause of death: Cerebral Hemmorhage	3 mos.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

SIGNATURE: Chester Riland, M.D. M. D. or other

Address: 2532 Edmondson Ave Baltimore (23) Date signed: 4-28-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85-a)

03403

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A. A.
City or town Arnold
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A. A.
City or town Arnold
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary C. Gray

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	colored	married

6.(b) Name of husband or wife Wm. Evans

6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Sept. 30 1870

8. AGE: Years	Months	Days	If less than one day
75	6		hrs. min.

9. Birthplace St Margretts A.A.Co.
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business

FATHER
12. Name Louis Stephens
13. Birthplace A. A.

MOTHER
14. Maiden name Mary F. Fleetwood
15. Birthplace A. A.

16. Informant Mrs Florida Miller
Address Arnold. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apl. 17 46 (month) (day) (year)
Cemetery or crematory Broadneck
Location St. Margretts.

18. Funeral director J. B. Johnson
Address Annapolis

19. April 16 1946 (Date rec'd by registrar) C. Brandt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1946 at 2 40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 44 to April 13 1946
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Arterial Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE R. C. Richardson M. D. or other
Address Annapolis, Md Date signed 4/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03404

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 yrs.

Hospital, Institution, or street address where death occurred:

Emergency Hospt. Annapolis Md.

How long in hospital or institution? Admitted 3/10/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 36 Clay St. Annapolis Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: ********** ********** **

3.(a) FULL NAME

Annetta Virginia Green

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6.(b) Name of husband or wife: **********

6.(c) If alive, give age: **** years

7. Birth date of deceased (mo., day, yr.): January 11, 1920

8. AGE: Years	Months	Days	If less than one day
26	2	3	....hrs. ....min.

9. Birthplace: Baltimore City Md.
(Town, county, and state)

10. Usual occupation: Maid work

11. Industry or business: None

FATHER
12. Name: Scott Green
13. Birthplace: Virginia

MOTHER
14. Maiden name: Annie Colbert
15. Birthplace: Washington D. C.

16. Informant: Bertha Viola Diggs

Address: 36 Clay St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/7/46 (month) (day) (year)

Cemetery or crematory: Brew Hill Cemetery

Location: West St. Extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. April 5 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1946, at 3:55 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 30 1946 to Apr 3 1946 and that I last saw her alive on Apr 2 1946

Immediate cause of death	DURATION
Toxemia	1 Mo
Due to: Burns	1 Mo
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Mar 30 1946

Where did injury occur? Annapolis (City or town) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Dress caught fire injured at home

23. SIGNATURE: R. T. Williams MD (M. D. or other)

Address: Annapolis Md. Date signed: 4-4-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (168-M)

CERTIFICATE OF DEATH

03405 23
Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Percy McGuire Griffin

3. (b) Social Security Number: 242-20-4408

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dorothy B. Bullick
6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): October 2[illegible] 1910

8. AGE:

Years	Months	Days	If less than one day
35	5	1	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Electric Welder
11. Industry or business: Maryland Drydock Co.

FATHER
12. Name: Richard Taswell Griffin
13. Birthplace: Edgecombe Co. N. C.

MOTHER
14. Maiden name: Lucy Barnhill
15. Birthplace: Halifax Co. N. C.

16. Informant: James Randolph Griffin
Address: Rocky Mount, N. C. R.F.D #3

17. Ship To (Burial, cremation, or removal. Which?) Date thereof: Apr 23 1946 (month) (day) (year)
Cemetery or crematory
Location: Rocky Mount, N. C.

18. Funeral director: Thomas W. Laughton
Address: Glen Burnie, Md.

19. April 23 19 46 (Date rec'd by registrar) Mabel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 1946, at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 19[illegible], to [illegible] 19[illegible]
and that I last saw h[illegible] alive on [illegible] 19[illegible]

Immediate cause of death	DURATION
asphyxia due to.	
illuminating gas.	Sudden
Due to (suicide)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 4/22/46.
Where did injury occur? Bradley Sta. A.A. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home.
Means of injury Injured at work?

23. SIGNATURE: Justice D. Faulconer M.D.
M. D. or other
Address: Glen Burnie Date signed 4/22/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

03406

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 410 Severn Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 410 Severn Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Annie E. Griscom

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

8.(b) Name of husband or wife: Ferdinand Griscom
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 18th 1866

8. AGE:

Years	Months	Days	If less than one day
80	0	11	hrs. min.

9. Birthplace: Annapolis, A.A.Co. Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business: —

FATHER
12. Name: Patty S. Brewer
13. Birthplace: A. A. Co. Md.

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

18. Informant: Mrs. C. A. Davis
Address: Eastport - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 1st 1946 (month) (day) (year)
Cemetery or crematory: Cedar Bluff Cemetery
Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son
Address: 149 Gloucester St. Annapolis

19. April 30 19 46
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 19 46, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 19 to Apr. 29 19 46 and that I last saw h.c.l. alive on August 29 19 45

Immediate cause of death: Pulmonary Tuberculosis — DURATION
Due to: Tuberculosis of the Larynx
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. Linthicum M. D. or other
Address: Eastport, Md. Date signed: Apr. 29, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03402

P

CERTIFICATE OF DEATH

Reg. Diat. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Linthicum Heights - R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Linthicum Heights.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Homeland Park.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Philipp Israbowski (alias Israels).

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife: Josephine Lisiecki.
6.(c) If alive, give age: 46 years
7. Birth date of deceased (mo., day, yr.): June 15 - 1885

8. AGE: Years	Months	Days	If less than one day
61	10	10	hrs. min.

9. Birthplace: Poland (Town, county, and state)
10. Usual occupation: Teamster - Laborer.
11. Industry or business:
FATHER 12. Name: William Israbowski
13. Birthplace: Poland.
MOTHER 14. Maiden name: Julia Stepopka
15. Birthplace: Poland.
16. Informant: Mrs. P. Israbowski (wife)
Address: Linthicum Heights, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/27/46 (month) (day) (year)
Cemetery or crematory: Sacred Heart of Mary
Location: Baltimore
18. Funeral director: Fred W. Ozazowski
Address: 930 Forrest Ave
19. 4/26 1946 A.W. Heduck M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1946, at 11.15 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	OURATION
Coronary Occlusion	Sudden
Due to: Pulmonary Tuberculosis.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gustave H. Paulenbrud (Acting Medical Examiner) M.D. or other
Address: Glen Burnie, Md. Date signed: 4-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03407

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A. A.
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
601 2nd st.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A. A.
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 601 2nd st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Gross.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Edna Gross.
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21 1890

8. AGE: Years 55 Months 10 Days 8 If less than one day hrs. min.

9. Birthplace Shadyside, Md.
(City, county, and state)

10. Usual occupation Labor

11. Industry or business

FATHER 12. Name William Gross
13. Birthplace A. A. Co.

MOTHER 14. Maiden name Serena (unknown)
15. Birthplace A. A.

16. Informant Edna Gross
Address 601 2nd St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2 1946 (month) (day) (year)
Cemetery or crematory St. Luke
Location Shadyside, Md.

18. Funeral director J. B. Johnson
Address Annapolis

19. May 2 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 29 1946 at 5.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1946 to April 29, 1946 and that I last saw him alive on April 29, 1946

Immediate cause of death	DURATION
(a) Acute Interstitial Broncho-Pneumonia	1½ hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. L. Richardson M. D. or other
Address Annapolis, Md. Date signed 5/1/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03408

CERTIFICATE OF DEATH

Reg. Diat. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Churchton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Churchton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Gross

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	negro	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Feb. 5 1865

8. AGE: Years 81 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Churchton, P.A., Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Jacob Gross
13. Birthplace: A. A. Co.

MOTHER
14. Maiden name: Sarah Blunt
15. Birthplace: Md.

16. Informant: William Blunt
Address: Churchton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 6, 1946 (month) (day) (year)
Cemetery or crematory: Franklin Cem.
Location: Churchton Md

18. Funeral director: J B Johnson
Address: Annapolis. Md.

19. April 4 1946 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 3 1946 at 12-55 P. M.

21. I CERTIFY that death occurred on the date above stated; ~~I last attended deceased from~~
Post mortem Examination
~~and that I last saw him alive on~~ Apr. 3 1946

Immediate cause of death	DURATION
Acute Dilatation of Heart	
Due to: Chronic Myocarditis	
Due to: Arterial Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John McCaffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 4/3/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94-2

03409

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County H. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2
Hospital, institution, or street address where death occurred: Res. 110 Clay St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rear 110 Clay St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Henry ~~Hall~~ Hare

3.(b) Social Security Number

4. Sex: male
5. Color or race: colored
6.(a) Single, married, widowed, or divorced: Unknown
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Dec, 24 1906
8. AGE: Years: about 39 | Months: 4 | Days: 6 | If less than one day: ... hrs. ... min.
9. Birthplace: South Carolina (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business: Park Restaurant
FATHER 12. Name: Doc ~~Hall~~ Hare
FATHER 13. Birthplace: S. C.
MOTHER 14. Maiden name: Hacinda Terry
MOTHER 15. Birthplace: Ala.
16. Informant: Hazel Levain
Address: 17 Blackwood st, Boston Mass
17. Burial, cremation, or removal. Which? Burial Date thereof: May 9 1946 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Palatka, Florida
18. Funeral director: J. B. Johnson
Address: Annapolis, Md.
19. May 6 1946 (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 30 1946, at ... M
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased~~ Post mortem Examination and that I last saw him ~~alive~~ on ... 19...

Immediate cause of death	DURATION
Coronary occlusion	sudden
Due to: Coronary Sclerosis	autumn
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work? ...

23. SIGNATURE: John M. Coffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 5/3/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1248)

03410

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Anne Arundel
City or town Brooklyn Park (25)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years - 8 mos
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Anne Arundel
City or town Brooklyn Park (25)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 106 - 7th Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary A. Haslup

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Frankland Haslup
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 27, 1868

8. AGE: Years 78 | Months 2 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Co., Md
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Martin Rogers
13. Birthplace Ireland

MOTHER 14. Maiden name Anna McCullagh
15. Birthplace Ireland

16. Informant Mrs. Mary M. Frazier (Daughter)
Address 106 - 7th Ave., Brooklyn Pk. (25) Anne Arundel Co., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 27, 1946 (month) (day) (year)
Cemetery or crematory New Cathedral
Location Baltimore, Md.

18. Funeral director A. Howard Evans
Address 1400 S. Charles St., Balto. 30, Md.

19. 4/25 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1946, at 11:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1944 to April 24, 1946 and that I last saw h... alive on April 23, 1946

Immediate cause of death Acute Dilatation of Heart — DURATION 2 days

Due to Chronic Myocarditis — DURATION 1 year

Due to Senility — DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to ~~external causes~~, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE R. L. Campbell M. D. or other
Address 1644 Hanover St Balto (30) Date signed 4/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87

CERTIFICATE OF DEATH

03411

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 127 Market
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Selina Curry Holland

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife —
(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov - 18 - 1917

8. AGE:

Years	Months	Days	If less than one day
28	5	3	____ hrs. ____ min.

9. Birthplace Annapolis Md. (Town, county, and state)
10. Usual occupation Secratary
11. Industry or business
12. Name of father James E. Holland
13. Birthplace of father Annapolis Md.
14. Maiden name of mother Selina Curry
15. Birthplace of mother Annapolis Md
16. Informant Mrs Jas E. Holland
Address 127 Market St. Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 23 1946 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.
18. Funeral director John M. Taylor Jr.
Address Annapolis Md.
19. April 23 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 21 1946, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 1 1946 to Apr 21 1946
and that I last saw her alive on Apr 20 1946

Immediate cause of death	DURATION
Multiple sclerosis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE R W Williams MD
M. D. or other
Address 105 Bancroft Annapolis Date signed 4-22-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

03412

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (103)

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: P.O. Severn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years.
Hospital, Institution, or street address where death occurred: Elmhurst Station
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A-A.
City or town: P.O. Severn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Elmhurst station
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Sarah R. Halley

3.(b) Social Security Number: 237-32-4281

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	M.

6.(b) Name of husband or wife: Mr. Maurice Halley

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): 5/25/92

8. AGE:

Years	Months	Days	If less than one day
53	10	23	..... hrs. ..... min.

9. Birthplace: Sumpter - S.C.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business: Own Home

FATHER
12. Name: James B. Richardson
13. Birthplace: Clarendon Co. S.C.

MOTHER
14. Maiden name: Mary Spencer
15. Birthplace: Connecticut.

16. Informant: Mr. Maurice Halley
Address: Elmhurst Station

17. Ship To (Burial, cremation, or removal. Which?) Date thereof: Apr 19, 1946 (month) (day) (year)

Cemetery or crematory:
Location: Charlotte N. C.

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. April 19 1946 (Date rec'd by registrar) M. Deale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1946, at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Heart Acute	
Circulatory disease	Sudden.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work?

23. SIGNATURE: Samuel H. Pauley, Md. M. D. or other
acting medical examiner
Address: Glen Burnie, Md. Date signed: 4/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21st)

CERTIFICATE OF DEATH

03413 P

23

Reg. Diat. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: A. A. Co

City or town: Brooklyn Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Brooklyn Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1- 6th Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Caroline Jager

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Married

6.(b) Name of husband or wife: Louis C.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 4- 1875

8. AGE: Years	Months	Days	If less than one day
70	9	23	..... hrs. ..... min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER 12. Name: John Kelly

FATHER 13. Birthplace: Baltimore Md.

MOTHER 14. Maiden name: Margaret Schafer

MOTHER 15. Birthplace: Baltimore Md.

16. Informant: Louis C. Jager

Address: 1- 6th Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-30-1946 (month) (day) (year)

Cemetery or crematory: Holy Cross ce. A. A. Co.

Location: A. A. Co. Md.

18. Funeral director: Flynn & Flynn

Address: 1426 Light St.

19. 4/29/46 J. C. Carpenter Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27- 1946 at 7 15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1946 to April 27 1946 and that I last saw h.. alive on April 27 1946

Immediate cause of death	DURATION
Myocardial degeneration	
Due to	
Due to	
Other conditions: Arteriosclerosis, Cystectomy, Myocardosis	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: John A. Schenck M.D.

Address: 837 S. Charles St. M. D. or other

Date signed: 4/28/46

MARYLAND STATE DEPARTMENT OF HEALTH

03414 P

2411 N. Charles St., Baltimore (73-D)

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months, 13 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 7 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1432 Presstman Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: JONES - MARY

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: George Jones

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): Jan. 20. 1894

8. AGE:

Years	Months	Days	If less than one day
52	unknown		--- hrs. --- min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ---

FATHER
12. Name: Washington Smith
13. Birthplace: Virginia

MOTHER
14. Maiden name: Julia Lee
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof April 25, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore City

18. Funeral director: George G. Kelson

Address: 1303 Presstman Street, Baltimore, Md.

19. 4-25 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 19 46 at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 10 19 45 to April 23 19 46

and that I last saw her alive on April 23 19 46

Immediate cause of death	DURATION
Pleurisy	9 days
Hypertension	Known to us since 9/10/45
Due to: Chronic Myocarditis	
Due to: ---	
Other conditions: Senile Psychosis	Known to us since 9/10/45

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did Injury occur? --- (City or town) --- (County) --- (State)

Injured at home, farm, industry, public place (where?): ---

Means of Injury: --- Injured at work? ---

23. SIGNATURE: Albert V. Bruckner
M. D. or other

Address: Crownsville, Maryland Date signed 4/23/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

★ 03415 Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 years

Hospital, institution, or street address where death occurred:
died in basement of Annapolis High School

How long in hospital or institution? ★★★★★★★★★★★★★★★

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Smithville, outside Annapolis Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Jones - William

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Single

6.(b) Name of husband or wife: ★★★★★★★★★★★★★★★★★★★★

6.(c) If alive, give age: ★★★★ years

7. Birth date of deceased (mo., day, yr.): December 22, 1888

8. AGE:

Years	Months	Days	If less than one day
57	3		..... hrs. ..... min.

9. Birthplace: Annapolis Md. A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: janitor

11. Industry or business: None

FATHER
12. Name: William Jones Sr.
13. Birthplace: A. A. Co. Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: A. A. Co. Md.

16. Informant: Abraham Wallace

Address: Smithville, Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/25/46 (month) (day) (year)

Cemetery or crematory: Brew Hill Cemetery

Location: West St. extd Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St Annapolis Md.

19. April 25 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-22 1946, at 8:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..im alive on Post mortem 4-22 1946.

Immediate cause of death	DURATION
Heart failure	Sudden.
Due to: prob. Coronary thrombosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E Leander Jarrett M.D.
Acting Coroner M. D. or other
Address: 172 Green St. Annapolis. Date signed 4-22-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157a)

03416

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A. Co.

City or town Glenburnie (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County A. A. Co.

City or town Glenburnie (If outside city or town limits, write RURAL and give nearest town)

Street No. 19 Manor Road (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Joan Kines

3.(b) Social Security Number

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 30-1945

8. AGE: Years — Months 4 Days 24 If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Charles T. Kines

13. Birthplace Baltimore Md.

MOTHER 14. Maiden name Vivian W. Crowne

15. Birthplace Baltimore

16. Informant Mrs Chas. T. Kines

Address 19 Manor Road.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-24-1946 (month) (day) (year)

Cemetery or crematory Cathedral Cemetery

Location Baltimore Md.

18. Funeral director Flynn & Fleming

Address 1426 Light St.

19. 4/24 1946 (Date rec'd by registrar) A. W. Hedrick D.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1946, at 2 30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1946 to April 23 1946

and that I last saw her alive on 4/23/46 19

Immediate cause of death meningitis

Due to Infected meningocele

Due to Hydrocephaly

DURATION: Congenital

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — injured at work?

23. SIGNATURE Gustave H. Faulkner M. D. or other

Address Glen Burnie Md Date signed 4/23/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

03417

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A.

City or town Lansbiccum Hts.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos.

Hospital, Institution, or street address where death occurred: 303 E. Hilltop Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A A

City or town Lansbiccum
(If outside city or town limits, write RURAL and give nearest town)

Street No. 303 E. Hilltop
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Celeste Diggs Klinglehoger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widow

6.(b) Name of husband or wife George J. Klinglehoger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 5 1862

8. AGE: Years	Months	Days	If less than one day
83	11	15	..... hrs. ..... min.

9. Birthplace Va
(Town, county, and state)

10. Usual occupation None

11. Industry or business (School Teacher)

FATHER 12. Name Wm James Diggs

13. Birthplace Va

MOTHER 14. Maiden name Catherine Warren

15. Birthplace Va

16. Informant ~~J. Frankel~~ Diggs Jr

Address 303 E. Hilltop Rd

17. Burial (Burial, cremation, or removal. Which) Date thereof 4-22-46 (month) (day) (year)

Cemetery or crematory Taylor Chapel Cem

Location Bulle Md.

18. Funeral director Leonard J. Rose

Address 5305 Halford Rd.

19. 4-20 19 46 Authority per TN Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1946 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1946 to April 19 1946

and that I last saw h alive on April 19 1946

Immediate cause of death	DURATION
Cardio-vascular Renal	5 hrs
Due to	
Due to	
Other conditions Intestinal Obstruction	36 hrs
Cause unknown	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas L. Bare Jr MD
M. D. or other

Address Lansbiccum Date signed 4-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 415

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

03418

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months 19 days.
Hospital, institution, or street address where death occurred:
U.S.S. REINA MERCEDES
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Florida County: Orange
City or town: Plymouth
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME
Calvin (n) LEANORD

3.(b) Social Security Number
Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: none
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7/31/26

8. AGE:

Years	Months	Days	If less than one day
19	08	20	..... hrs. ..... min.

9. Birthplace: Plymouth, Orange, Florida
(Town, county, and state)
10. Usual occupation: Steward's Mate Second Class
11. Industry or business: U.S. Navy

FATHER
12. Name: Richard White (L. P.) ite
13. Birthplace: Plymouth, Florida

MOTHER
14. Maiden name: Mrs. Lilian Leanord White
15. Birthplace: Plymouth, Florida

16. Informant: CO, USS REINA MERCEDES
Address: Annapolis, Maryland

17. Remodel (Burial, cremation, or removal. Which?) Date thereof: April 25/46 (month) (day) (year)
Cemetery or crematory:
Location: Orlando Florida
18. Funeral director: B. L. Hagan
Address: Annapolis, Md.
19. April 25 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 1946, at 6:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 8 1945, to December 10 1945
and that I last saw h.. alive on Dec. 10 1945

Immediate cause of death	DURATION
Drowning	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no evidence of violence Date of op.
Autopsy results: Lungs filled with fluid
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank M Lloyd PhM (M) USNR M. D. or other
Address: US naval Hospital Annapolis, Md. Date signed: 4/25/46

W

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

03419

Reg. Dist. No. 2

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? -

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Annapolis, Md.

How long in hospital or institution? 12 hours 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Iowa County:

City or town: Oelwein, (If outside city or town limits, write RURAL and give nearest town)

Street No. 36 Seventh Ave. S. E. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: BABY GIRL "LEEHEY" -- Louise

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Infant

6.(b) Name of husband or wife: Father Patrick Leehey

6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): April 19, 1946

8. AGE: Years | Months | Days | If less than one day: 12 hrs. 05 min.

8. Birthplace: Annapolis, Anne Arundel Co. Md. (Town, county, and state)

10. Usual occupation: Infant (Premature)

11. Industry or business

FATHER
12. Name: Patrick Leehey
13. Birthplace: Waterloo, Iowa

MOTHER
14. Maiden name: Dorothy Irene Feltus
15. Birthplace: Oelwein, Iowa.

16. Informant: U. S. NAVAL HOSPITAL
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 20/46 (month) (day) (year)

Cemetery or crematory: Navae

Location: annapolis. Md

18. Funeral director: B. E. Hopkins

Address: annapolis Md

19. April 20 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1946 at 1:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1946 to April 19 1946 and that I last saw her alive on April 19 1946

Immediate cause of death: Prematurity	DURATION
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. R. Monk M. D. or other

Address: U.S. Naval Hospital Annapolis, Md. Date signed 4/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03420

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 264 King George St.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 264 King Geo. St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Helen Marie Mace

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 16th 1894

8. AGE: Years: 52 | Months: — | Days: 4 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Annapolis - A.A.Co. - Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business: —

FATHER
12. Name: J. Louis Mace
13. Birthplace: Annapolis - Md.

MOTHER
14. Maiden name: Agnes P. Clark
15. Birthplace: Annapolis - Md.

16. Informant: Mrs. James F. Robert
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 23rd 1946 (month) (day) (year)
Cemetery or crematory: St. Anns Cemetery
Location: Annapolis Md.

18. Funeral director: John M. Taylor & Son
Address: Annapolis, Md.

19. April 22 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1946, at 3.45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1946 to April 20 1946
and that I last saw him alive on April 19 1946

	DURATION
Immediate cause of death: Acute Dilatation of Heart	Hidden
Due to: Cr. Myocarditis	Several yrs.
Due to: Cr. Pulmonary TB	about 20 yrs. or more
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: Helen Turner M. D. or other
Address: Annapolis Md. Date signed 4/20/46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 03421 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 hours
Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, ANNAPOLIS, MD.
How long in hospital or institution? 10 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Riva
(If outside city or town limits, write RURAL and give nearest town)
Street No. Sylvan Shores
(If rural, give LOCATION)
2.(a) If veteran, name war World War One and Two

3. (a) FULL NAME Leroy Malcum Mc Callum

3. (b) Social Security Number Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	US(W)	Married

6.(b) Name of husband or wife (Wife Elsie Mc Callum) 8.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 6 March 1888

8. AGE: Years	Months	Days	If less than one day
58	1	18	..... hrs. ..... min.

9. Birthplace Madison, Indiana (Town, county, and state)

10. Usual occupation USN (Ret.)

11. Industry or business USN (Ret)

FATHER
12. Name John Mc Callum
13. Birthplace Unknown

MOTHER
14. Maiden name Mary Hines
15. Birthplace Unknown

16. Informant Elsie Mc Callum
Address Sylvan Shores, Riva, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof April 29/46 (month) (day) (year)
Cemetery or crematory arlington national
Location arlington va

18. Funeral director Hopping Funeral Home
Address Annapolis, Maryland

19. April 26 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 April 1946 19..... at 9:09 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Noon 24 April 1946 to 9:09 PM. 24 April 1946
and that I last saw him alive on 8:30 PM 24 April 1946

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Cerebral Hemorrhage	10 hrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

T. S. Harbin

23. SIGNATURE T. S. HARBIN, Lieut. (MC) USNR M. D. or other
Address U. S. Naval Hospital, Annapolis, Md. Date signed .....

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (67)

CERTIFICATE OF DEATH

03422

FILM No. I 0 1 APR - 9 1946

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

12 Francis Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Francis Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Eliza McCormick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 20th, 1868

8. AGE: Years	Months	Days	If less than one day
77	5	12	..... hrs. ..... min.

9. Birthplace Annapolis - A. A. Co. - Maryland (Town, county, and state)

10. Usual occupation Nurse

11. Industry or business —

MOTHER FATHER

12. Name Alexander H. McCormick

13. Birthplace Washington, D.C.

14. Maiden name Isabella Howard

15. Birthplace Washington D.C.

16. Informant Mrs. Howard McCormick

Address Acton Place, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3rd 1946 (month) (day) (year)

Cemetery or crematory Congressional Cemetery

Location Washington, D.C.

18. Funeral director John M. Taylor & Son

Address Annapolis, Maryland

19. April 3 1946 (Date rec'd by registrar)

W Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1946, at 7:25 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5, 1946, to Apr. 1, 1946 and that I last saw h.. alive on Apr. 1, 1946

	DURATION
Immediate cause of death Cachexia	7 months
Due to Carcinomatosis	1 yr.
Due to Carcinoma of liver?	1½ yrs.
Other conditions Senility	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James R. Martin, M.D. M. D. or other

Address 185 Prince George St. Annapolis, Md. Date signed 4-7-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A16 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3d)

CERTIFICATE OF DEATH

03423

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel County
City or town Quarter Field Rd Severna Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A A County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. Quarter Field Rd Severna Md
(If rural, give LOCATION)
2.(a) If veteran, name war W

3. (a) FULL NAME Mary McEnaney

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Philip
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 6 1867

8. AGE: Years 79 | Months 2 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Edward Stertel
FATHER 13. Birthplace Holland

MOTHER 14. Maiden name Amelia Miller
MOTHER 15. Birthplace Germany

16. Informant Owen A McEnaney
Address Quarter Field Rd Severna Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 9 1946 (month) (day) (year)
Cemetery or crematory Glen Haven
Location Glen Burnie Md

18. Funeral director W A Owings
Address 117 S Paul St Baltimore Md

19. 4-9-46 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946, at 12:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15-46 to April 6-46 1946
and that I last saw h[illegible] alive on April 5-46 1946

Immediate cause of death	DURATION
Acute Heart Failure	
Due to	
Due to Cardiovascular Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address [illegible] Date signed April 8-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

03424

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 8 mos., 20 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 yrs, 8 mos, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Camp Parole
(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

3.(a) FULL NAME: McGOWAN - FANNIE (FRANCES)

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	married

6.(b) Name of husband or wife: George McGowan

Camp Parole, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): February 28, 1889 (?)

8. AGE: Years: 57 ? Months: 1[illegible]11 Days: If less than one day: ---- hrs. ---- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -----

FATHER
12. Name: Sam Downs
13. Birthplace: West River, Md.

MOTHER
14. Maiden name: Henrietta Sanders
15. Birthplace: West River, Md.

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Apr. 13, 1946 (month) (day) (year)

Cemetery or crematory: Chew's Cemetery

Location: Owensville, Maryland

18. Funeral director: J. B. Johnson
Address: Annapolis, Maryland

19. April 11 1946 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1946, at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 19 1943, to April 9 1946 and that I last saw her alive on April 9 1946

Immediate cause of death	DURATION
Chronic Mycarditis and Nephritis	Known to us since 7/19/43
Due to: ------	
Due to: ------	
Other conditions: Huntington's Chorea	Known to us since 7/19/43

(Include pregnancy within 3 months of death)

Major findings of operations: --------

Date of op.: -----

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of: -----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?): --------

Means of injury: -------- Injured at work? -----

23. SIGNATURE: Albert L. Winbrook M. D. or other

Address: Crownsville, Maryland Date signed: 4/9/46

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 03425 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: A A.
City or town: Crownsville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 801 Frederick Rd Catonsville 28
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Robert Baxter McRary

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C.	M.

6.(b) Name of husband or wife: Mrs. Katherine Mc. Rary

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): — 1861

8. AGE:

Years	Months	Days	If less than one day
85	—	—	..... hrs. ..... min.

9. Birthplace: N.C (Town, county, and state)

10. Usual occupation: Teacher Pk. D Retired

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Hospital Record
Address: Crownsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 25 1946 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Park
Location: Baltimore Co. Md.

18. Funeral director: Mrs. George A. Holland
Address: 1601 Orchid Hill Ave.

19. 4-26 46 Recording (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 1946, at 6.50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12 1946 to April 22 1946
and that I last saw him alive on April 22 1946

	DURATION
Immediate cause of death: General Arteriosclerosis	Known to us since April 12-46
Due to:	
Due to:	Known to us since April 12 46
Other conditions: Dysphonia will Cerebr. Arteriosclerosis (Include pregnancy within 3 months of death)	

Major findings of operations: —
Date of op.: —
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Herb. L. Hartzog M. D. or other
Address: Crownsville, Md Date signed: April 23, 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3d)

CERTIFICATE OF DEATH

03426 1

Reg. Dist. No. .....

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County A. A. Co.

City or town Harmons

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Harmons

(If outside city or town limits, write RURAL and give nearest town)

Street No. Dorsey Rd

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Claude B. Merson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Laura V. Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 20, 1877

8. AGE: Years	Months	Days	If less than one day
68	9	21	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Artimus Merson

13. Birthplace Maryland

MOTHER 14. Maiden name Mary White Leaf

15. Birthplace Maryland

16. Informant Mr. John Merson

Address 1026 S. Paca St

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/13/46 (month) (day) (year)

Cemetery or crematory Friendship

Location Friendship Md

18. Funeral director Harry H. Wilkes

Address 4101 E. Monument Ave.

19. 4-13 19 46 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 19 46, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 19 46, to April 10 19 46

and that I last saw h[illegible] alive on April 10 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage.	12 days
Due to Cardio. Vascular Renal	3 years
Due to	.....
Due to	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE James S. Ballenger M.D. M. D. or other

Address Glen Burnie Md. Date signed April 14 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

03427

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Jessups, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 days
Hospital, institution, or street address where death occurred:
Maryland House of Correction
How long in hospital or institution? Hospital--36 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Jessups
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Maryland House of Correction
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William E. Mitchell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col'd	Married

6.(b) Name of husband or wife: Ida May Mitchell
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 1893

8. AGE: Years	Months	Days	If less than one day
52	7	7	hrs. min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Records, M.H.C.
Address:

17. Burial (Burial, cremation, or removal, Which?) Date thereof 5/1/46 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Anne Arundel County

18. Funeral director: A. Hasbel
Address: 918 Druid Hill Ave-

19. April 29 1946 (Date rec'd by registrar) Ward Kasluh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28, 1946 19 at 4:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22, 1946 to April 28, 1946
and that I last saw him alive on April 27 1946

Immediate cause of death	DURATION
Toxemia	
Due to Extravasation of urine scrotal & pubic	
Due to old urethral stricture	
Other conditions Suprapubic cystotomy	

(Include pregnancy within 3 months of death)

Major findings of operations: perforation of urethra behind a stricture Date of op. Mar. 23/46.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John A Clark M.D.
M. D. or other
Address: Md. House of Correction Date signed Apr. 28/46

03428

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Harmd. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred: none.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Harmd. Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs Ida Jane Brady Moreland

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	married

6.(b) Name of husband or wife: Morris George Moreland.
~~If widow, of~~ 6.(c) If alive, give age 73 years
7. Birth date of deceased (mo., day, yr.) Feb 10 - 1873

8. AGE:

Years	Months	Days	If less than one day
73	2	12	....hrs. ....min.

9. Birthplace: anne arundel (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: Samuel Brady -
13. Birthplace: Calvert County.

MOTHER
14. Maiden name: Martha Anne Cheney
15. Birthplace: Calvert County

16. Informant: Geoge Morris Moreland.
Address: Harmd. Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof April 24/46 (month) (day) (year)
Cemetery or crematory: Mt Zion. M.E.
Location: Mt Zion rd
18. Funeral director: C. F. Hopping
Address: Annapolis. Md.

19. Apr 23 46 (Date rec'd by registrar) H. P. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22, 1946, at 11 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 1946 to April 22 1946 and that I last saw h.. alive on April 22, 1946

Immediate cause of death	DURATION
Coronary occlusion	
Due to arteriosclerosis, hypertension	
Due to Chronic myocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D. M. D. or other
Address: Lothian, Md. Date signed 4/22/46

MARYLAND STATE DEPARTMENT OF HEALTH

03429

2411 N. Charles St., Baltimore (155)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 118 Charles St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Garret Porter Morgan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Roy L. Morgan
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 15th 1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
66	4	3		

9. Birthplace: Annapolis, A.A. Co. Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business: —
FATHER 12. Name: James C. Porter
13. Birthplace: Annapolis, Md.
MOTHER 14. Maiden name: Minnie C. Smith
15. Birthplace: Baltimore, Md.
16. Informant: Roy P. Morgan
Address: Annapolis, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 20, 1946 (month) (day) (year)
Cemetery or crematory: St. Annes Cemetery
Location: Annapolis, Md.
18. Funeral director: John M. Taylor & Son
Address: Annapolis, Maryland
19. April 20 1946 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1946, at 69 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1946, to April 18 1946
and that I last saw h[illegible] alive on April 18 1946

Immediate cause of death: Acute Myocarditis — DURATION: 3 days
Due to: Primary Anaemia — 1 yrs.
Due to: Aplastic Splenosis — 1 years
Due to: Paget's Disease — 1 years
Due to: Pathological Fracture — 8 days
Other conditions: H. Hyp.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C Basil M. D. or other
Address: Annapolis Md Date signed: 4-18-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

03430

2411 N. Charles St., Baltimore (93rd)

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years 10 months
Hospital, Institution, or street address where death occurred:
CROWNSVILLE STATE HOSPITAL
How long in hospital or institution? 10 years 10 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Calvert County
City or town: Plum Point
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MARION MORSELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown 1901 ?

8. AGE: Years: 45? Months: Days: If less than one day: hrs. min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: "

MOTHER
14. Maiden name: Edmonia Reed
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 9 1946 (month) (day) (year)
Cemetery or crematory: Plum Point
Location: Calvert Md.

18. Funeral director: P. E. Sewell
Address: Prince Frederick, Md.

19. 4/8 1946 (Date rec'd by registrar) E. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7, 1946, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8, 1935, to April 7, 1946 and that I last saw her alive on April 6, 1946

Immediate cause of death	DURATION
chronic myocarditis	1 year
Due to	about
Due to	
Other conditions: mental defective with psychosis	10yr.10mo.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: none
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Date signed April 8, '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

03431 P

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 6 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 6 months, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 234 North Carey Street
(If rural, give LOCATION)
2.(a) If veteran, name war: --------

3.(a) FULL NAME: NICHOLSON - ESTHER

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: John Nicholson 234 N. Carey St. Baltimore, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1888

8. AGE: Years: 58 Months: unknown Days: If less than one day: ---hrs. ---min.

8. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ------

FATHER
12. Name: Jerry Hopkins
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jannie ?
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: April 25, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore City

18. Funeral director: Mrs. Katie R. Williams
Address: 322 N. Schroeder St., Balto., Md.

19. 4/24 1946 (Date rec'd by registrar) A. W. Hedrick S.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 19 46 at 6:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 16 19 45, to April 22 19 46 and that I last saw her alive on April 22 19 46

Immediate cause of death	DURATION
General Paresis	Known to us since 10/16/45
Due to: -------	
Due to: -------	
Other conditions: -------	

(Include pregnancy within 3 months of death)

Major findings of operations: ---------
Date of op.: -------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --------- Date of: -------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---------
Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Albert J. Stinchcomb M. D. or other
Address: Crownsville, Maryland Date signed: 4/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS (A15) 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

03432

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Deale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 64 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Deale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: Mary Phipps

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	

6.(b) Name of husband or wife: Thomas E. Phipps
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 3 1862

8. AGE: Years: 83 | Months: 11 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Cumberstone A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: At home

11. Industry or business:

FATHER
12. Name: Joseph Knapp
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Miller
15. Birthplace: Germany

16. Informant: Bernard Phipps
Address: Deale Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 20 1946 (month) (day) (year)
Cemetery or crematory: St James
Location: Tracys Md.

18. Funeral director: E. A. Stanley & Son
Address: Galesville Md.

19. April 20 1946 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 1946 at 12 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Dec 28 1945 and that I last saw h.er alive on Dec 28 1945

Immediate cause of death	DURATION
Degenerative cardiac Disease	10 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. Williams M.D. M. D. or other
Address: % S Borsack, Annapolis Md. Date signed: 4-19-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

03443

P

CERTIFICATE OF DEATH

Reg. Dist. No. 28

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Supply every item of information carefully. PLEASE WRITE PLAINLY, WITH UNFADING INK.

MARGIN RESERVED FOR BINDING

M

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William Rhodes

3. (b) Social Security Number:

4. Sex: M.
5. Color or race: Black
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): unknown 1886
8. AGE: Years 60? Months — Days — If less than one day ... hrs. ... min.
9. Birthplace: Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Henry Rhodes
13. Birthplace: Md
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: Hospital Records
Address: Crownsville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4 24 46 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemetery
Location: Cedar Hill Md.
18. Funeral director: Adolphus Hatslag
Address: 9 & Dun? Hill ave
19. 4/24 1946 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1946, at 10:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13, 1946 to April 20 1946 and that I last saw him alive on April 20, 1946
Immediate cause of death: Generalized arteriosclerosis — DURATION: Before admission to the hospital
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [illegible signature] M. D. or other
Address: Crownsville, Md. Date signed: 4-21-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1950)

03444

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Jessup (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? five days
Hospital, Institution, or street address where death occurred: Maryland House of Correction Hospital
How long in hospital or institution? three days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 603 N. Bond St. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Richard Sawyer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col'd	married

6.(b) Name of husband or wife: Catherine Sawyer
6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): July 16, 1916

8. AGE: Years	Months	Days	If less than one day
29	8	27	....hrs. ....min.

9. Birthplace: Norfolk, Va. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: John Wm. Sawyer
13. Birthplace: N.C.

MOTHER
14. Maiden name: Clara
15. Birthplace: Norfolk, Va.

16. Informant: sister
Address: 603 N. Bond St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 16-1946 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemetery
Location: A. A. Co., Md.

18. Funeral director: Robert E. Williams
Address: 1515 McElderry St Balto 5 Md

19. April 12 1946 (Date rec'd by registrar) Leland Lashley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1946 at 230 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....
and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Convulsions of tetanus	
Due to: Tetanus infection incurred in an injury to scalp (hit	
Due to: with a brick thrown by unknown person or persons)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: blow on head Date of: Mar. 26/46
Where did injury occur? Baltimore (City or town) Md. (State)
Injured at home, farm, industry, public place (where?): street
Means of injury: struck by brick Injured at work?

23. SIGNATURE: Gordon H. Pancoast M.D.
Assistant Medical Examiner M. D. or other
Address: Glen Burnie Md. Date signed: 4/17/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS (A15)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

03445

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 33 Maryland Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No.: 33 Maryland Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Albert J. Scala

3.(b) Social Security Number: 214-05-0563

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Angelina Scala

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): March 27th 1874

8. AGE: Years 72 Months 1 Days 2 If less than one day ... hrs. ... min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: Retired Fruit and

11. Industry or business: Grocery Merchant

FATHER
12. Name: Louis Scala
13. Birthplace: Italy

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Mrs. A. J. Scala

Address: 33 Maryland Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 2d 1946 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Annapolis, Maryland

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Maryland

19. May 1 1946 (Date rec'd by registrar)

Registrar: [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 29 1946, at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; Postmortem Examination Apr. 29 1946

Immediate cause of death	DURATION
Acute Dilation of Heart	Sudden
Due to: Cardio-Vascular Disease	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner, M. D. or other

Address: Annapolis, Md. Date signed: 4/30/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03446

Reg. Dist. No. 26.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Shady Side

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Shady Side Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clifton Scott

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Widowed

8.(b) Name of husband or wife: Sarah Scott

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 4. 1884

8. AGE:

Years	Months	Days	If less than one day
61	4	3	..... hrs. ..... min.

9. Birthplace: Shady Side (Town, county, and state)

10. Usual occupation: Oysterman

11. Industry or business

FATHER — 12. Name: Jacob Scott

FATHER — 13. Birthplace: Shady Side

MOTHER — 14. Maiden name: Matilda Thompson

MOTHER — 15. Birthplace: Churchton

16. Informant: Vera Robinson

Address: Shady Side Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 10, 1946 (month) (day) (year)

Cemetery or crematory: St Matthews Cem

Location: Shady Side Md.

18. Funeral director: J. E. Hardesty & Son

Address: Galesville Md.

19. April 10, 1946 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 7th 1946, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 1945 to April 7, 1946 and that I last saw him alive on April 7, 1946

Immediate cause of death	DURATION
Cerebral apoplexy	1 week.
Due to: Arterial Hypertension	1 year
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. E. Buchanan M. D. or other

Address: Annapolis, Md. Date signed 4/8/46


RECEIVED
APR 12 1948
BUREAU OF

Evidence for addition of usual residence of deceased is shown on FILM No. I 0 1 APR 15 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73rd)

CERTIFICATE OF DEATH

03447

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Edgewater
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Edgewater P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: County Home
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Frank Sherback

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 28 1865

8. AGE: Years	Months	Days	If less than one day
80	6	4	hrs. min.

9. Birthplace: Germany (Town, county and state)
10. Usual occupation:
11. Industry or business

FATHER
12. Name: —
13. Birthplace: —

MOTHER
14. Maiden name: —
15. Birthplace: —

16. Informant: Mrs Wm Tucker
Address: Edgewater Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Apr 3, 1946 (month) (day) (year)
Cemetery or crematory: A.A. Co. Home Farm
Location: Edgewater, Md
18. Funeral director: H.A. Handley & Son
Address: Galesville Md.

19. Apr 3 1946 (Date rec'd by registrar) Edmund Colleran Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 2 1946, at 12 45' P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1946, to April 2 1946; and that I last saw him alive on March 31 1946.

Immediate cause of death	DURATION
(a) Pulmonary Edema	5 min.
Due to: Chr. myocarditis & Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. J. Klawans, M.D. (M. D. or other)
Address: 31 South gate Av Date signed: 4/3/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

03448

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:
County Anne Arundel
City or town Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Anne Arundel
City or town Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5707 Johnson St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Conrad Simon

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Margaret
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Apr 4 1870
8. AGE: Years: 76 Months: 0 Days: 0 If less than one day ..... hrs. ..... min.
9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Dept Head Mill Supplies Retired
11. Industry or business
FATHER 12. Name: Unknown
13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
15. Birthplace: Germany
16. Informant: Paul Simon
Address 5707 Johnson St Brooklyn
17. Buried (Burial, cremation, or removal. Which?) Date thereof 4/5/46 (month) (day) (year)
Cemetery or crematory Concordia
Location Ft Wayne Ind
18. Funeral director Mullholm & Sons
Address 1314 E Fort St
19. 4/5 1946 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 1946, to April 1 1946
and that I last saw h. alive on April 1 1946

	DURATION
Immediate cause of death: coronary occlusion	
Due to: hypertension cardio-vascular disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Philip W. Reisch MD M. D. or other
Address 302 Patapsco Av Date signed 4/4/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

★ 103449

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Skidmore Md. R. F. D. #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 53 years
Hospital, institution, or street address where death occurred:
Skidmore Md. A. A. Co.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Skidmore Md. A. A. Co.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: None
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Cornelius Smith

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Married

6.(b) Name of husband or wife: Louise Smith
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): April 1893

8. AGE: Years	Months	Days	If less than one day
53			....hrs. ....min.

9. Birthplace: Skidmore A. A. C. Md.
(Town, county, and state)
10. Usual occupation: Fisherman
11. Industry or business: None

FATHER
12. Name: John Smith
13. Birthplace: Skidmore Md.

MOTHER
14. Maiden name: Elizabeth Holland
15. Birthplace: Skidmore Md.

16. Informant: Mr Abram Smith
Address: Annapolis Md. R. F. D. Box 410

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/28/46 (month) (day) (year)
Cemetery or crematory: Broad Neck Cemetery
Location: Skidmore Md.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. April 27, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1946 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-29 1946 to 4-25 1946 and that I last saw h[illegible] alive on 4-25- 1946

Immediate cause of death	DURATION
Pneumonia	
Due to	
Due to	
Other conditions Debility & paralysis	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: .... Injured at work?

23. SIGNATURE: A. T. Alley M. D.
M. D. or other
Address: 17 Carroll St Date signed 4-26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03450

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred:
87 Washington St. Annapolis Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 87 Washington St.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Joseph Eugene Spriggs

3.(b) Social Security Number: 215-12-8175

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Single

6.(b) Name of husband or wife: ********************

6.(c) If alive, give age: *** years

7. Birth date of deceased (mo., day, yr.): November 8, 1915

8. AGE: Years	Months	Days	If less than one day
30			hrs. min.

9. Birthplace: Annapolis Md.
(Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business: None

FATHER
12. Name: Charles R. Spriggs
13. Birthplace: Annapolis Md.

MOTHER
14. Maiden name: Anetia Cook
15. Birthplace: Annapolis Md.

16. Informant: Mrs Aneita Cook Spriggs
Address: 87 Wsahington St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/21/46 (month) (day) (year)

Cemetery or crematory: St. Anne Cemetery

Location: Northwest St. extd.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Nottrwset St. Annapolis Md.

19 April 20 19 46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/19 19 46 at 1 26 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/15 19 46 to 4/19 19 46 and that I last saw him alive on 4/19 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 mon.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Theodore H. Johnson M. D.
M. D. or other

Address: 40 Walbert Street Date signed: 4/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 03451 Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: a a

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: Herald Harbor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Milton P. Sterling Jr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7 July 1945

8. AGE:

Years	Months	Days	If less than one day
	9	21	..... hrs. ..... min.

9. Birthplace: annapolis. md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Milton P Sterling Sr

13. Birthplace: maryland

MOTHER 14. Maiden name: Pauline A McDough

15. Birthplace: Hampton Roads Va

16. Informant: Milton P Sterling Sr

Address: Herald Harbor Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 1 1946 (month) (day) (year)

Cemetery or crematory: Catholic

Location: Millersville. md

18. Funeral director: B. L. Hopkins

Address: annapolis. md

19. May 1 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 28 1946, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 28 1946, to Apr. 28 1946.

and that I last saw h.. alive on Apr. 28 @ 1:45 1946.

Immediate cause of death	DURATION
Atelectasis	24 hrs
Due to: Aspiration of mucus (?)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Atelectasis - massive - both lungs.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Elizabeth Peabody Trevett MD (M. D. or other)

Address: 172 Green St Date signed: 4.29.46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P

03452

Reg. Dist. No. 25

1. PLACE OF DEATH:
County A. A. Co.
City or town Brooklyn (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? abt. 5 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County A. A. Co.
City or town Brooklyn (If outside city or town limits, write RURAL and give nearest town)
Street No. 515 Hammonds Lane (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Doney Stevens

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Mitchell Stevens
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Aug. 21, 1888

8. AGE: Years	Months	Days	If less than one day
57			..... hrs. ..... min.

9. Birthplace Bosnia, Yugoslavia (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. Name of father George Mavjovitch
13. Birthplace
14. Maiden name of mother Unknown
15. Birthplace
16. Informant George Stevens (son)
Address 515 Hammonds Lane
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-14-1946 (month) (day) (year)
Cemetery or crematory Mt. Olivet
Location New York
18. Funeral director Flynn & Fleming
Address 1476 Light St.
19. 4-13- 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1946, at 1:45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1946, to April 12 1946
and that I last saw h[illegible] alive on April 11 1946
Immediate cause of death Bronchopneumonia Rt lung
Aneurysm aorta ?
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

DURATION
1 week
?

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Milton B. Kress M. D. or other
Address Medarts Bldg Date signed April 13 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

03453

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Garland Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Ferndale Md. P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 315 Orchard Road (Garland Park)
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Henry J. Stolze

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah L. Stolze, Nee Wickham
6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): October 16, 1858

8. AGE: Years: 87 | Months: 5 | Days: 18 | If less than one day: ...hrs. ...min.

9. Birthplace: St. Clairsville, Ohio (Town, county, and state)

10. Usual occupation: Pottery Store Keeper (Retired)

11. Industry or business: Wheeling W. Va

FATHER
12. Name: Henry Stolze
13. Birthplace: Germany

MOTHER
14. Maiden name: Dorothea Beckey
15. Birthplace: Baden Germany

16. Informant: Mr. George A. Stolze.
Address: Burial Ferndale, Md.

17. Shipped (Burial, cremation, or removal. Which?) Date thereof: Apr 6, 1946 (month) (day) (year)

Cemetery or crematory:
Location: Wheeling, W. Va.

19. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. April 5 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4, 1946, at 11.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~April~~ 3/4, 1946, to 4/3/46, 19...
and that I last saw him alive on 4/3/46, 19...

Immediate cause of death	DURATION
Heart failure	6 hrs.
Due to: senility	?
Due to: arterio-sclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ...Injured at work?

23. SIGNATURE: Gustave D. Pauker M.D. M. D. or other
Address: Glen Burnie Md. Date signed: 4/5/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

★ 0345428 — Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr, 3 mos, 3 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 1 yr, 3 mos, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ———
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1318 Fremont Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: TABBS - MARY

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: ———
6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): 1875?

8. AGE: Years: 71 ? Months: unknown Days: If less than one day: ——— hrs. ——— min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: ———

FATHER
12. Name: Harien Dorsey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie Hicks
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 2, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Anne Arundel County

18. Funeral director: Elroy Wilson
Address: 1000 Brantley Ave., Baltimore, Md.

19. Apr 29 1946 (Date rec'd by registrar) E. Joyce Locke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 19 46 at 5:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 25 19 45 to April 28 19 46 and that I last saw her alive on April 28 19 46

	DURATION
Immediate cause of death: General Arteriosclerosis	Known to us since 1/25/45
Due to: ———	
Due to: ———	
Other conditions: Psychosis with Cerebral Arteriosclerosis	Known to us since 1/25/45

(Include pregnancy within 3 months of death)

Major findings of operation: ——— Date of op.: ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of: ———
Where did injury occur? (City or town) (County) (State): ———
Injured at home, farm, industry, public place (where?): ———
Means of injury: ——— Injured at work? ———

23. SIGNATURE: Paul J. Winterode M. D. or other
Address: Crownsville, Maryland Date signed: 4/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-0)

CERTIFICATE OF DEATH

03455

Reg. Dist. No.

1. PLACE OF DEATH:
County Anne Arundel
City or town Old Glory Beach, Dolly's, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 8 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Anne Arundel
City or town Old Glory Beach, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #2, Dolly's, P.O. Co., Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James A. Taylor

3. (b) Social Security Number 217-03-6974

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Marie M. Taylor (Nee Wedemeyer) 6.(c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) November 8, 1892

8. AGE: Years 53 | Months 8 (5) | Days — | If less than one day — hrs. — min.

9. Birthplace Lancaster Co., Va. (Town, county, and state)

10. Usual occupation Millwright

11. Industry or business Davison Chemical Corp.

FATHER 12. Name James R. Taylor

FATHER 13. Birthplace Va.

MOTHER 14. Maiden name Alice Elizabeth (Nee Taylor)

MOTHER 15. Birthplace Va.

16. Informant Mrs. Marie M. Taylor, (Wife)
Address Old Glory Beach, Rural Route #2, Dolly's, Anne Arundel Co., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 11, 1946 (month) (day) (year)

Cemetery or crematory Cedar Hill Cem.

Location A. A. Co., Md.

18. Funeral director A. Howard Evans

Address 1400 S. Charles St., Balto. 30, Md.

19. 4-10 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1946 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5 1946 to April 8 1946 and that I last saw him alive on April 8 1946.

	DURATION
Immediate cause of death	
Due to. Cyanosis of Lungs Left	
Due to.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Rubin M.D. M. D. or other

Address 203 Baltimore Ave. Date signed 4/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 102

CERTIFICATE OF DEATH

03456

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Lehuchtine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. Co.
City or town: Lehuchtine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME Theophilus Thompson

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Widowed

6.(b) Name of husband or wife: Alice Cornelius Brown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 7. 1850

8. AGE: Years	Months	Days	If less than one day
95	10	2	..... hrs. ..... min.

9. Birthplace: Lehuchtine (Town, county, and state)
10. Usual occupation: At home
11. Industry or business
FATHER 12. Name: Thomas Thompson
13. Birthplace: Md
MOTHER 14. Maiden name: Mary A. Taylor
15. Birthplace: Lehuchtine
16. Informant
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 28 1946 (month) (day) (year)
Cemetery or crematory: Franklin Mem.
Location: Lehuchtine Md
18. Funeral director: F. G. Hardisty & Son
Address: Lakeville Md.
19. April 25 1946 (Date rec'd by registrar) D. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25. 1946, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1. 1946, to April 25 1946
and that I last saw h.. alive on April 23 1946

Immediate cause of death	DURATION
Cardiac failure	
Due to: old age	
Due to: Pneumonia, Lobar	
Duration: ten days. C.W.G.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Geo. L. Adams M. D. or other
Address: 1520 9th N.W. Date signed: 4/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 250

CERTIFICATE OF DEATH

03433 Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 827 West St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John W. Lydings Tydings

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Margaret Lydings
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 27th 1873

8. AGE: Years 72 Months 6 Days 25 If less than one day hrs. min.

9. Birthplace A. A. Co Md. (Town, county, and state)
10. Usual occupation Painter
11. Industry or business
FATHER 12. Name John Lydings
13. Birthplace A. A. Co Md.
MOTHER 14. Maiden name Annie Steward
15. Birthplace A. A. Co Md.
16. Informant Margaret Lydings Tydings
Address 827 West St. Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24 1946 (month) (day) (year)
Cemetery or crematory Ledon Bleye
Location Annapolis Md.
18. Funeral director Robert F. Duvall
Address Annapolis Md.
19. April 24 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 19 46, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 45 to April 22 19 46 and that I last saw him alive on April 22 19 46

Immediate cause of death	DURATION
Myocarditis (chr).	2 yrs
Hypertension	2 yrs
Due to	
Due to	
Other conditions Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C. Bacil M. D. or other
Address Annapolis Md Date signed 4.24.46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

03434

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hours 2 min.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Severn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Washington Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Albert C. Wayman

3.(b) Social Security Number: 172-16-7730

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Betty Jane Wayman Callahan
6.(c) If alive, give age: 26 years
7. Birth date of deceased (mo., day, yr.): August 7, 1920

8. AGE:

Years	Months	Days	If less than one day
25	8	14	..... hrs. ..... min.

9. Birthplace: Connellsville Pa. (Town, county, and state)
10. Usual occupation: Pigment Blender
11. Industry or business: National Plastic Co. Odenton, Md.

FATHER
12. Name: John Wayman
13. Birthplace: Pt. Marion, Fayette Co., Pa

MOTHER
14. Maiden name: Etna Smith
15. Birthplace: Fayette Co. Pa.

16. Informant: Mrs. Albert C. Wayman
Address: #1 Willis St. Uniontown Pa.

17. Ship Via-B.&O.R.R. (Burial, cremation, or removal. Which?) Date thereof: April 17, 1946 (month) (day) (year)
Cemetery or crematory:
Location: Uniontown Pa.

18. Funeral director: Thomas W. Slaughter
Address: Glen Burnie, Md.

19. April 17 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 16 1946, at 10:20 A. M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination and ~~that I last saw him alive on~~ Apr. 16 1946

Immediate cause of death	DURATION
Burned to death	
Due to: Trapped in Blending	
Due to: Fire & explosion	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident. Date of: Apr. 16, 1946
Where did injury occur? Odenton (City or town) A. A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): National Plastic Corp.
Means of injury: Fire + explosion Injured at work? Yes

23. SIGNATURE: John M. Cleary M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 4/16/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

03435

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr, 10 mos, 13 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 yrs, 10 mos, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 830 Bradley Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: WARREN - PEARL

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	unknown

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1894 ?

8. AGE: Years: 52 ? Months: unknown Days: If less than one day: ---- hrs. ---- min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: ------

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

18. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-14-46 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville

18. Funeral director: Supt.
Address: Crownsville

19. (Date rec'd by registrar) May 14 1946 E. F. Doyle Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 1946, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1944, to April 29 1946 and that I last saw her alive on April 28 1946

Immediate cause of death	DURATION
Cerebral Arteriosclerosis	Known to us since 6/16/44
Due to: ------	
Due to: ------	
Other conditions: Senile Psychosis	Known to us since 6/16/44

(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op.: ------

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of: ------
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ------
Means of injury: ------ Injured at work? ------

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 4/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 5.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4602)

CERTIFICATE OF DEATH

03436

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 530 First St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Douglas Waterman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Britton Waterman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 25th 1871

8. AGE:

Years	Months	Days	If less than one day
74	6	9	..... hrs. ..... min.

9. Birthplace Bordentown N. J. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business Mining Engineer
FATHER 12. Name Augustus Waterman
13. Birthplace Phila Pa
MOTHER 14. Maiden name Katherine Thompson
15. Birthplace Bordentown N. J.
16. Informant Katherine Thompson
Address 530 First St. Eastport Md
17. Cremation (Burial, cremation, or removal. Which?) Date thereof April 4th 1946 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Prince Geo Co. Md.
18. Funeral director John M. Taylor & Son
Address Annapolis Md.
19. April 4 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1946, at 10.20 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March — 1946, to April 3 1946
and that I last saw h.. alive on April 3 1946

Immediate cause of death	DURATION
Carcinoma	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Cystonomy. Suprapubic of large tumor. Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE E. Gilbert M. D. or other
Address Eastport, Maryland Date signed 4/4/46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

03437 Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs, 8 mos, 28 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 8 yrs, 8 mos, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 82 (?) Calvert Street
(If rural, give LOCATION)
2.(a) If veteran, name war: -------

3.(a) FULL NAME: WEEMS - RHODA

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: -------
6.(c) If alive, give age ------ years

7. Birth date of deceased (mo., day, yr.): February 14, 1893 ?

8. AGE:

Years	Months	Days	If less than one day
53 ?	2	0	--- hrs. --- min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: -----

FATHER
12. Name: Louis B. Weems
13. Birthplace: Maryland

MOTHER
14. Maiden name: Georgiana Kemp
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof April 17, 1946 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West St. Extended, Annapolis, Md.

18. Funeral director: Mrs. Charles E. Hicks
Address: 45 N. West St., Annapolis, Maryland

19. April 16 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1946, at 1:35 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1937 to April 14 1946 and that I last saw her alive on April 13 1946

Immediate cause of death	DURATION
Lung Tuberculosis	Known to us about 2 weeks
Due to: ----------	
Due to: ----------	
Other conditions: Dementia Praecox	Known to us since 7/16/37

(Include pregnancy within 3 months of death)

Major findings of operations: --------
Date of op. -------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -------- Date of -------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -------
Means of injury -------- Injured at work? -------

23. SIGNATURE: Stuart S. Hinkwood M. D. or other
Address: Crownsville, Maryland Date signed 4/13/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

03438

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

Reg. Dist. No. 27

M

I

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Regional Hospital, Ft. Geo. G. Meade, Maryland
How long in hospital or institution? 2 months and 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State GERMANY County
City or town Wiesensteiten, Kreis Horb, Whertemberg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war (German Prisoner Of War)

3. (a) FULL NAME JOHANN WEKERLE

3. (b) Social Security Number 31G-50178

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife (Sister) Christine Wekerle
Same address as (2) 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11th, 1907

8. AGE: Years	Months	Days	If less than one day
38	9	15	hrs. min.

9. Birthplace GERMANY
(Town, county, and state)
10. Usual occupation Construction worker
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden name —
15. Birthplace —

16. Informant Medical Records & Service Records
Address U.S. Army, Ft. Geo. G. Meade, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/29/46 (month) (day) (year)
Cemetery or crematory Post Cemetery
Location Fort George G. Meade, Md.

18. Funeral director Howard N. Blight Jr.
Address 4914 Belair Road.

19. 27 April 1946 (Date rec'd by registrar) ALLAN G. BROTZMAN, 2d Lt., (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 April 1946 19 at 2230 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1700 hr. 24 April 1946 to 2230 hr 26 Apr. 1946 and that I last saw h.i.m. alive on 26 April 1946

Immediate cause of death	DURATION
Cachexia and peripheral vascular collapse	
Due to Carcinomatosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op. metastases
Autopsy results Carcinoma of Stomach & abdominal
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jerry B. Swim, Capt. M.C. M. D. or other
Address Reg. Hosp. Ft. Meade, Md. Date signed 6 May 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

★ 03439

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
33 Maryland Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 33 Maryland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Francis Olin White, Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ruth E. White

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 31, 1883

8. AGE: Years	Months	Days	If less than one day
63	4	29	hrs. min.

9. Birthplace: Annapolis, A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: Newspaperman (ret.)

11. Industry or business

FATHER 12. Name: Francis O. White, Sr.

FATHER 13. Birthplace: Annapolis, Md.

MOTHER 14. Maiden name: Martha E. Dye

MOTHER 15. Birthplace: Kentucky

18. Informant: Clarence M. White
Address: West Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/30/46 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Md.

19. April 30 19 46 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 28 19 46 at 10:00 A. M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmortem Examination to ~~and that I last saw [redacted] alive on~~ Apr. 28, 19 46

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to: Coronary sclerosis	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John M. Caffey M.D., Deputy Medical Examiner
M. D. or other

Address: Annapolis, Md. Date signed 4/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (119-a)

03440

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Ann Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Ann Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lucile Marie White

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	—

6.(b) Name of husband or wife
April 20, 1946 6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 20, 1946

8. AGE: Years	Months	Days	If less than one day
0	0	5	hrs. min.

9. Birthplace Annapolis, A. A. Co. Md.
(Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name Gustavous White
13. Birthplace A. A. Co.
MOTHER 14. Maiden name Mary Frances Robinson
15. Birthplace Annapolis. Md
16. Informant Gustavous White
Address Annapolis, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29 1946 (month) (day) (year)
Cemetery or crematory Brewers Hill
Location Annapolis, Md.
18. Funeral director J. B. Johnson
Address Annapolis Md.
19. April 29 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1946 at 7:55 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-25 1946 to 4-25 1946 and that I last saw h.r. alive on 4-25-46 1946

Immediate cause of death	DURATION
Shock & dehydration	
Due to Diarrhea & vomiting	
Due to Gastro-enteritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. T. Alley M.D.
M. D. or other
Address 17 Carroll St. Date signed 4-26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 6-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

03441

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 28 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 4 months, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Marion Station (If outside city or town limits, write RURAL and give nearest town)

Street No. Box #260 (If rural, give LOCATION)

2.(a) If veteran, name war: ———

3.(a) FULL NAME: WHITTINGTON - WILLIAM

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ———

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): January 12, 1931

8. AGE: Years 15 | Months 3 | Days 2 | If less than one day: ——— hrs. ——— min.

9. Birthplace: Marion Station, Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business: ———

FATHER — 12. Name: unknown

13. Birthplace: unknown

MOTHER — 14. Maiden name: Estella Whittington (?)

15. Birthplace: Marion Station, Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 18-46 (month) (day) (year)

Cemetery or crematory: Asamah

Location: marion sta md

18. Funeral director: Chas H Ward

Address: marion md

19. April 16 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1946 at 3:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 16 1945 to April 14 1946 and that I last saw him alive on April 14 1946

Immediate cause of death	DURATION
Status Epilepticus	
Due to: ———	
Due to: ———	
Other conditions: Idiot (Include pregnancy within 3 months of death)	Known to us since 11/16/45

Major findings of operations: ——— Date of op. ———

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work? ———

23. SIGNATURE: Herbert A. Sanderson M. D. or other

Address: Crownsville, Maryland Date signed: 4/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

03442

CERTIFICATE OF DEATH

Reg. Diat. No. 20

1. PLACE OF DEATH:
County Anne Arundel
City or town Mayo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Mayo
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Wier

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Vanorden Wier
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Nov 24th 1877
8. AGE: Years 68 Months 5 Days 1 If less than one day ..... hrs. ..... min.
9. Birthplace: A. A. Co Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Joseph A. Lee
13. Birthplace: A. A. Co Md.
MOTHER 14. Maiden name: Rebecca Purdy
15. Birthplace: A A Co Md.
16. Informant: Vanorden Wier
Address: Mayo. A.A.C. Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof Apr 28th 1946 (month) (day) (year)
Cemetery or crematory: Hope Chapel
Location: Mayo. Md.
18. Funeral director: Robert T. Smith
Address: Annapolis Md.
19. April 27 1946 (Date rec'd by registrar) Edward Collins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1946 at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20, 1946 to Apr. 25, 1946 and that I last saw b[illegible] alive on April 25, 1946

Immediate cause of death: Cachexia — DURATION: 2 months.
Due to: Carcinoma of Sigmoid Colon
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Carcinoma of Sigmoid Colon — Date of op. 1941
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE James R. Martin, M.D. (M. D. or other)
Address 165 Prince George St. Annapolis, Md. Date signed 4/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

STATE OF MARYLAND—CERTIFICATE OF DEATH 13457

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 25

Village or City Brooklyn Park No. 4502 Rockie Highway St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Lizzie Price If U. S. Veteran, specify WAR

(a) Residence: No. ... St., ... Ward. ...

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W.	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Price

6. DATE OF BIRTH (month, day, and year) Jan - 1871

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75 -			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Home wife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) Baltimore

FATHER

13. NAME Kleymansith

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Margaret Bachman

16. BIRTHPLACE (city or town) (State or country) Baltimore

17. INFORMANT Mr. Harry Price

(Address) 4502 Rockie Highway.

18. BURIAL, CREMATION, OR REMOVAL

Place Mt Olivet Date 4/13/46, 19...

19. UNDERTAKER J. J. Bakey Sons

(Address) 1318 Light St.

20. FILED April 12, 1946 Ida M. Whitens

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April (Month) 10th (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from April 3rd, 1946, to April 10, 1946.

I last saw her alive on April 10, 1946; deeth is said to have occurred on the date stated above, at 6:50 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral hemorrhage	4/3/46
	8 days
Other Contributory Causes of Importance: General and cerebral arterio sclerosis.	?

Name of operation ... Date of ...

What test confirmed diagnosis? Phys. Findings Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ...

Nature of injury ...

24. Wes disease or injury in any way related to occupation of deceased? No

If so, specify ...

(Signed) H. Harry Deitel M. D.

(Address) 1226 Hanover St.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN